



## Sponsorship & Charitable Donations Request Form

**NOTE:** All requests must be submitted on this form to the Corporate Planning & Development Department a minimum of 12 weeks prior to date needed. **Please fill out this form completely.** This is required in order for request to be processed. *Additionally, all requests must have supporting documentation attached with information on the event, purpose, sponsorship levels, etc.*

**MAIL TO:** Hattiesburg Clinic, Corporate Planning & Development | 415 S. 28th Avenue, Hattiesburg, MS 39401  
**FAX TO:** (601) 261-3601 **OR** **EMAIL TO:** publicrelations@hattiesburgclinic.com

**DATE:** \_\_\_\_\_ **IS YOUR ORGANIZATION A 501(C) 3:**  Yes  No

**DATE RESPONSE IS NEEDED FOR SPONSORSHIP RECOGNITION:** \_\_\_\_\_ (must be 12 weeks from date turned in)

**ORGANIZATION NAME:** \_\_\_\_\_

**HAS HATTIESBURG CLINIC SPONSORED THIS EVENT IN THE PAST?**  Yes  No If yes, when: \_\_\_\_\_

**TYPE OF ORGANIZATION:**  For-Profit Business  Non-profit

**WEBSITE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**FEDERAL TAX ID NUMBER** (or Social Security Number, if individual): \_\_\_\_\_

*The Federal Tax ID number or SSN is needed if a monetary donation is requested so the organization or individual may be entered into the Hattiesburg Clinic vendor system and a check issued. **A W-9 needs to accompany this request.***

**REQUEST MADE BY:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

Hattiesburg Clinic is committed to supporting initiatives that support health, education and community development. Please indicate what initiative this project/event supports and describe how this project/event provides opportunities for the clinic to support the community.

**PLEASE CHECK WHICH INITIATIVE THIS REQUEST WOULD FALL UNDER:**

- Health  Education  Economic/Community Development

**SUPPORT REQUESTED:**

- Sponsorship  Charitable Contribution  Ad Sponsorship (attach all info)  Novelty Items

If monetary, please specify amount requested: \_\_\_\_\_

*Please continue on back.*

Information on the event or request must be attached in order to be processed. All event/project documentation should also be attached.

EVENT NAME:

WHAT IS THE PURPOSE OF THE EVENT?

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ LOCATION: \_\_\_\_\_

ESTIMATED ATTENDANCE: \_\_\_\_\_ LAST YEAR'S ATTENDANCE: \_\_\_\_\_

PRIMARY AGE GROUP OF ATTENDEES: \_\_\_\_\_

WILL HATTIESBURG CLINIC BE ACKNOWLEDGED AS A CONTRIBUTOR/SPONSOR? IF SO, HOW?

Contact person will be notified as to whether or not the sponsorship is approved and at what level.

CONTACT NAME:

CONTACT PHONE: \_\_\_\_\_ CONTACT EMAIL: \_\_\_\_\_

CHECK PAYABLE TO: \_\_\_\_\_

CHECK MAILING ADDRESS: \_\_\_\_\_

Please attach all supporting documents.

A photo or other proof of advertisement must be submitted, along with an evaluation, (which can be found on [www.hattiesburgclinic.com](http://www.hattiesburgclinic.com)) to [prmanager@hattiesburgclinic.com](mailto:prmanager@hattiesburgclinic.com) after the event to be considered for future sponsorships/donations.

SEND PROOF OF ADVERTISEMENT AND THIS APPLICATION TO:

MAIL TO: Hattiesburg Clinic, Corporate Planning & Development ~ 415 S. 28th Avenue ~ Hattiesburg, MS 39401

FAX TO: 601-261-3601 Email to: [prmanager@hattiesburgclinic.com](mailto:prmanager@hattiesburgclinic.com)

For more information, call 601-261-3689.

## Office Use Only

DATE RECEIVED: \_\_\_\_\_ APPROVED: \_\_\_\_\_ DECLINED: \_\_\_\_\_

REASON: \_\_\_\_\_

LEVEL OF PARTICIPATION:

Check requested       Door Prize Given       Ad Submitted

Other \_\_\_\_\_

CONTACT PERSON NOTIFIED: (DATE) \_\_\_\_\_ (BY): \_\_\_\_\_